CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Amendment)

907 KAR 1:045. Reimbursement provisions and requirements regarding community mental health center services.

RELATES TO: KRS 205.520(3), 210.370

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6313, 42 C.F.R. 447.325, 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement provisions and requirements regarding community mental health center services provided to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. Definitions. (1) "Community board for mental health or individuals with an intellectual disability" means a board established pursuant to KRS 210.380.

(2) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

(3) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(4)[~~(2)~~] "Department" means the Department for Medicaid Services or its designee.

(5)[~~(3)~~] "Enrollee" means a recipient who is enrolled with a managed care organization.

(6)[~~(4)~~] "Federal financial participation" is defined by 42 C.F.R. 400.203.

(7) "Federal Register" means the official journal of the United States federal government that publishes government agency rules and public notices.

(8) "Healthcare Common Procedure Coding System code" means a billing code:

(a) Recognized by Medicare; and

(b) Monitored by the Centers for Medicare and Medicaid Services.

(9) "Injectable drug" means an injectable, infused, or inhaled drug or biological that:

(a) Is not excluded as a non-covered immunization or vaccine;

(b) Requires special handling, storage, shipping, dosing, or administration; and

(c) Is a rebatable drug.

(10) "Interim reimbursement" means a reimbursement:

(a) In effect for a temporary period of time; and

(b) That does not represent final reimbursement for services provided during the period of time.

(11)[~~(5)~~] "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(12) "Medicaid allowable costs" means the costs:

(a) Associated with the Medicaid-covered services:

1. Listed in Section 12 of this administrative regulation:

a. Rendered to recipients who are not enrollees; and

b. Not rendered as a 1915(c) home and community based waiver services provider; and

2. Covered pursuant to 907 KAR 1:046:

a. Rendered to recipients who are not enrollees; and

b. Not rendered as a 1915(c) home and community based waiver services provider; and

(b) Determined to be allowable costs by the department.

(13) "Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report" means a report developed and owned by the Medical Group Management Association which:

(a) Highlights the critical relationship between physician salaries and productivity;

(b) Is used to align physician salaries and benefits with provider production; and

(c) Contains:

1. Performance ratios illustrating the relationship between compensation and production; and

2. Comprehensive and summary data tables that cover many specialties.

(14) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(15) "Medicare Economic Index" means a measure of inflation:

(a) Associated with the costs of physicians' practices; and

(b) Published in the Federal Register.

(16) "Payment plan request" means a request to pay an amount owed to the department over a period of time approved by the department.

(17)[~~(6)~~] "Provider" is defined by KRS 205.8451(7).

(18) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(19)[~~(7)~~] "Recipient" is defined by KRS 205.8451(9).

(20) "State fiscal year" means the period beginning on July 1 of a year and ending on June 30 of the following year.

Section 2.General Reimbursement Provisions. (1) The department shall reimburse a participating in-state community mental health center under this administrative regulation for services:

(a) If the services are:

1. Covered pursuant to:

a. 907 KAR 1:044; or

b. 907 KAR 1:046;

2. Not provided by the CMHC acting as a 1915(c) home and community based waiver services provider;

3. Provided to recipients who are not enrolled with a managed care organization; and

4. Medically necessary; and

(b) Based on the community mental health center's Medicaid allowable costs.

(2) The department's reimbursement shall include reimbursing:

(a) On an interim basis during the course of a state fiscal year; and

(b) A final reimbursement for the state fiscal year that results from a reconciliation of the interim reimbursement amount paid to the CMHC by the department compared to the CMHC's Medicaid allowable costs for the state fiscal year.

Section 3. Interim Reimbursement for Primary Care Services. (1) The department's interim reimbursement to a CMHC for primary care services shall be the reimbursement established for the service on the current Kentucky-specific Medicare Physician Fee Schedule.

(2) If no reimbursement for a given service exists on the current Kentucky-specific Medicare Physician Fee Schedule, the department shall reimburse on an interim basis for the service as it reimburses for services pursuant to 907 KAR 3:010.

Section 4. Interim Reimbursement for Injectable Drugs. The department's interim reimbursement for the cost of injectable drugs administered in a CMHC shall be the reimbursement methodology established in 907 KAR 3:010 for injectable drugs.

Section 5. Interim Reimbursement for Behavioral Health Services through June 30, 2016. (1)(a) To establish interim rates for behavioral health services effective for dates of service through June 30, 2016, the department shall use a CMHC's most recently submitted cost report that meets the requirements established in paragraph (b) of this subsection.

(b) The cost report shall:

1. Be in a format that has been approved by the Centers for Medicare and Medicaid Services; and

2. State all of the:

a. CMHC's Medicaid allowable costs:

(i) For Medicaid-covered services rendered to recipients during the period beginning July 1, 2013 and ending June 30, 2014; and

(ii) For Medicaid-covered injectable drugs rendered to recipients during the period beginning July 1, 2013 and ending June 30, 2014 if the CMHC administered injectable drugs to recipients during the time period;

b. CMHC's costs associated with:

(i) Medicaid-covered services rendered to enrollees during the period beginning July 1, 2013 and ending June 30, 2014; and

(ii) Medicaid-covered injectable drugs rendered to enrollees during the period beginning July 1, 2013 and ending June 30, 2014 if the CMHC administered injectable drugs to enrollees during the time period;

c. Costs of the community board for mental health or individuals with an intellectual disability under which the CMHC operates for the period beginning July 1, 2013 and ending June 30, 2014; and

d. CMHC's costs associated with services rendered to individuals:

(i) That were reimbursed by an insurer or party other than the department or a managed care organization; and

(ii) During the period beginning July 1, 2013 and ending June 30, 2014.

(2) The department shall:

(a) Review the cost report referenced in subsection (1) of this section; and

(b) Establish interim rates for Medicaid-covered behavioral health services:

1. To be effective July 1, 2015;

2. Based on Medicaid allowable costs as determined by the department through its review; and

3. Intended to result in a reimbursement for Medicaid-covered behavioral health services:

a. Provided to recipients who are not enrollees;

b. For the period July 1, 2015 through June 30, 2016; and

c. That equals the department's estimate of behavioral health services' costs for the CMHC for the period.

Section 6. Final Reimbursement for Services Provided from January 1, 2015 through June 30, 2015. (1) By December 31, 2015, a CMHC shall submit a cost report to the department:

(a) In a format that has been approved by the Centers for Medicare and Medicaid Services;

(b) That has been audited by an independent auditing entity; and

(c) That states all of the:

1. CMHC's Medicaid allowable costs for Medicaid-covered services rendered to recipients during the period beginning July 1, 2014 and ending June 30, 2015;

2. CMHC's costs associated with Medicaid-covered services rendered to enrollees during the period beginning July 1, 2014 and ending June 30, 2015;

3. Costs of the community board for mental health or individuals with an intellectual disability under which the CMHC operates for the period beginning July 1, 2014 and ending June 30, 2015; and

4. CMHC's costs associated with services rendered to individuals:

a. That were reimbursed by an insurer or party other than the department or a managed care organization; and

b. During the period beginning July 1, 2014, and ending June 30, 2015.

(2) The department shall:

(a) Review the cost report referenced in subsection (1) of this section;

(b)1. Determine the amount of Medicaid allowable costs for the dates of service beginning January 1, 2015, through June 30, 2015; and

(c) Compare the amount of Medicaid allowable costs referenced in paragraph (b) of this subsection to the department's interim reimbursement for Medicaid-covered services provided during the dates of service beginning January 1, 2015, through June 30, 2015.

(3)(a) After the department compares a CMHC's interim reimbursement with the CMHC's Medicaid allowable costs for the period referenced in subsection (2) of this section, if the department determines that the interim reimbursement:

1. Was less than the CMHC's Medicaid allowable costs for the period, the department shall send a payment to the CMHC equal to the difference between the CMHC's total interim reimbursement and the CMHC's Medicaid allowable costs; or

2. Exceeded the CMHC's Medicaid allowable costs for the period, the:

a. Department shall send written notification to the CMHC requesting the total amount of the overpayment; and

b. CMHC shall, within thirty (30) days of receiving the department's written notice, send a:

(i) Payment to the department equal to the excessive amount; or

(ii) Payment plan request to the department.

(b) A CMHC shall not implement a payment plan unless the department has approved the payment plan in writing.

(c) If a CMHC fails to comply with the requirements established in paragraph (a)2 of this subsection, the department shall:

1. Suspend payment to the CMHC; and

2. Recoup the amount owed by the CMHC to the department.

Section 7. Final Reimbursement for a State Fiscal Year Beginning with State Fiscal Year 2016. (1)(a) Beginning with the state fiscal year that begins July 1, 2015, and ends June 30, 2016, by December 31 following the end of the state fiscal year, a CMHC shall submit a cost report to the department:

1. In a format that has been approved by the Centers for Medicare and Medicaid Services;

2. That has been audited by an independent auditing entity; and

3. That states all of the:

a. CMHC's Medicaid allowable costs:

(i) For Medicaid-covered services rendered to recipients during the prior state fiscal year; and

(ii) For Medicaid-covered injectable drugs rendered to recipients during the prior state fiscal year if the CMHC administered injectable drugs to recipients during the time period;

b. CMHC's costs associated with:

(i) Medicaid-covered services rendered to enrollees during the prior state fiscal year;

and

(ii) Medicaid-covered injectable drugs rendered to enrollees during the prior state fiscal year if the CMHC administered injectable drugs to enrollees during the time period;

c. Costs of the community board for mental health or individuals with an intellectual disability under which the CMHC operates for the prior state fiscal year; and

d. CMHC's costs associated with services rendered to individuals:

(i) That were reimbursed by an insurer or party other than the department or a managed care organization; and

(ii) During the prior state fiscal year.

(b) To illustrate the timeline referenced in paragraph (a) of this subsection, an independently audited cost report stating costs associated with services and injectable drugs provided during the state fiscal year spanning July 1, 2015, through June 30, 2016 shall be submitted to the department by December 31, 2016.

(2) By April 1 following the department's receipt of a CMHC's completed cost report submitted to the department by the prior December 31, the department shall:

(a) Review the cost report referenced in subsection (1) of this section;

(b) Determine the amount of Medicaid allowable costs on the cost report; and

(c) Compare the amount of Medicaid allowable costs referenced in paragraph (b) of this subsection to the department's interim reimbursement for Medicaid-covered services and injectable drugs rendered during the same state fiscal year.

(3)(a) After the department compares a CMHC's interim reimbursement with the CMHC's Medicaid allowable costs for the period, if the department determines that the interim reimbursement:

1. Was less than the CMHC's Medicaid allowable costs for the period, the department shall send a payment to the CMHC equal to the difference between the CMHC's total interim reimbursement and the CMHC's Medicaid allowable costs; or

2. Exceeded the CMHC's Medicaid allowable costs for the period, the:

a. Department shall send written notification to the CMHC requesting the amount of the overpayment; and

b. CMHC shall, within thirty (30) days of receiving the department's written notice, send a:

(i) Payment to the department equal to the excessive amount; or

(ii) Payment plan request to the department.

(b) A CMHC shall not implement a payment plan unless the department has approved the payment plan in writing.

(c) If a CMHC fails to comply with the requirements established in paragraph (a)2 of this subsection, the department shall:

1. Suspend payment to the CMHC; and

2. Recoup the amount owed by the CMHC to the department.

Section 8. Interim Reimbursement for Behavioral Health Services Beginning July 1, 2016. (1)(a) Effective July 1, 2016, and each subsequent July 1, to establish interim rates for behavioral health services for the state fiscal year the department shall:

1. Review the cost report submitted to the department by the preceding December 31; and

2. Establish interim rates for Medicaid-covered behavioral health services:

a. To be effective on the first day, July 1, of the next state fiscal year;

b. Based on Medicaid allowable costs as determined by the department through its review; and

c. Intended to result in a reimbursement for Medicaid-covered behavioral health services:

(i) Provided to recipients who are not enrollees;

(ii) During the next state fiscal year; and

(iii) That equals the department's estimate of behavioral health services' costs for the CMHC for the period.

(b) Interim rates for behavioral health services effective July 1 each year shall have been trended and indexed from the prior December 31 using the Medicare Economic Index.

(c) The cost report referenced in paragraph (a) of this section shall comply with the cost report requirements established in Section 7 of this administrative regulation.

(d) To illustrate the timeline referenced in paragraph (a) of this subsection, a cost reported submitted by a CMHC to the department on December 31, 2017, shall be used by the department to establish behavioral health services' interim rates effective July 1, 2018.

(2)(a) A behavioral health services interim rate shall not be subject to retroactive adjustment except as specified in this section.

(b) The department shall adjust a behavioral health services interim rate during the state fiscal year if the rate that was established appears likely to result in a substantial cost settlement that could be avoided by adjusting the rate.

(c)1. If the cost report from a CMHC has not been audited or desk-reviewed by the department prior to establishing interim rates for the next state fiscal year, the department shall use the cost report under the condition that interim rates shall be subject to adjustment as established in subparagraph 2 of this paragraph.

2. A behavioral health services interim rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

3. An unaudited cost report shall be subject to an adjustment to the audited amount after the auditing has occurred.

Section 9. New Services. (1) Reimbursement regarding a projection of the cost of a new Medicaid-covered service or expansion shall be made on a prospective basis in that the costs of the new service or expansion shall be considered when actually incurred as an allowable cost.

(2)(a) A CMHC may request an adjustment to an interim rate after reaching the mid-year point of the new service or expansion.

(b) An adjustment shall be based on actual costs incurred.

Section 10. Auditing and Accounting Records. (1)(a) The department shall perform a desk review of each cost report to determine whether an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used for purposes of verifying costs to be used in setting the interim behavioral health services rate or for purposes of adjusting interim behavioral health services rates which have been set based on unaudited data.

(2)(a) A CMHC shall maintain and make available any records and data necessary to justify and document:

1. Costs to the CMHC;

2. Services provided by the CMHC;

3. Drugs provided, if any, by the CMHC;

4. Cost allocations utilized including overhead statistics and supportive documentation; and

5. Any amount reported on the cost report.

(b) The department shall have unlimited on-site access to all of a CMHC's fiscal and service records for the purpose of:

1. Accounting;

2. Auditing;

3. Medical review;

4. Utilization control; or

5. Program planning.

(3) A CMHC shall maintain an acceptable accounting system to account for the:

(a) Cost of total services provided;

(b) Charges for total services rendered; and

(c) Charges for covered services rendered to eligible recipients.

(4) An overpayment discovered as a result of an audit or desk review shall be settled

through recoupment or withholding.

Section 11. Allowable and Non-allowable Costs. (1) The following shall be allowable costs:

(a) Services' or drugs' costs associated with the services or drugs;

(b) Depreciation as follows:

1. A straight line method shall be used;

2. The edition of the American Hospital Association's useful life guidelines currently used by the Centers for Medicare and Medicaid Services' Medicare program shall be used;

3. The maximum amount for expensing an item in a single cost report shall be $500; and

4. Only the depreciation of assets actually being used to provide services shall be recognized;

(c) Interest costs;

(d) Costs incurred for research purposes;

(e) Costs incurred for transporting recipients to services;

(f) Costs of motor vehicles used by management personnel up to $25,000;

(g) Costs for training or educational purposes outside of Kentucky including transportation costs to travel to the training or education;

(h) Costs associated with any necessary legal expense incurred in the normal administration of the CMHC;

(i) The cost of administrative staff salaries shall be limited to the average salary for the given position as established for the geographic area on **www.salary.com**; and

(j)1. The cost of practitioner salaries shall be limited to the median salary for the southern region as reported in the Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report, if available.

2. A per visit amount using MGMA median visits shall be utilized.

3. The most recently available MGMA publication that relates to the cost report period shall be used.

(2)(a) The allowable cost for a service or good purchased by a facility from a related organization shall be in accordance with 42 C.F.R. 413.17.

(3) The following shall not be allowable costs:

(a) Bad debt;

(b) Charity;

(c) Courtesy allowances;

(d) Political contributions;

(e) Costs associated with an unsuccessful lawsuit against the department or the Cabinet for Health and Family Services;

(f) Costs associated with any legal expense incurred related to a judgment granted as a result of an unlawful activity or pursuit;

(g) The value of services provided by non-paid workers;

(h) Travel or related costs or expenses associated with attending:

1. A convention;

2. A meeting;

3. An assembly; or

4. A conference; or

(i) Costs related to lobbying.

(4) A discount or other allowance received regarding the purchase of a good or service shall be deducted from the costs of the good or service for cost reporting purposes.

(5)(a) Maximum allowable costs shall be the maximum amount which may be allowed as reasonable cost for the provision of a service or drug.

(b) To be considered allowable, any cost shall:

1. Be necessary and appropriate for providing services; and

2. Not exceed usual and customary charges[~~as established in this subsection.~~

~~(a) The payment rate that was in effect on June 30, 2002, for the community mental health center for community mental health center services shall remain in effect and there shall be no cost settling.~~

~~(b) Allowable costs shall not:~~

~~1. exceed customary charges which are reasonable; or~~

~~2. Include:~~

~~a. The costs associated with political contributions;~~

~~b. Travel or related costs for trips outside the state (for purposes of conventions, meetings, assemblies, conferences, or any related activities);~~

~~c. The costs of motor vehicles used by management personnel which exceed $20,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel); or~~

~~d. Legal fees for unsuccessful lawsuits against the cabinet.~~

~~(c) Costs (excluding transportation costs) for training or educational purposes outside the state shall be allowable costs.~~

~~(2) To be reimbursable, a service shall:~~

~~(a) Meet the requirements of 907 KAR 1:044, Section 4(2); and~~

~~(b) Be medically necessary~~].

Section 12. Units of Service[~~3. Implementation of Payment System~~]. (1)(a) Interim payments shall be based on units of service.

(b) A unit for a primary care service shall be the amount indicated in the corresponding:

1. CPT code; or

2. Healthcare Common Procedure Coding System code.

(c) One (1) unit for each behavioral health service shall be defined as follows:

Service	Unit of Service
Individual Outpatient Therapy	15 minutes
Group Outpatient Therapy	15 minutes
Family Outpatient Therapy	15 minutes
Collateral Outpatient Therapy	15 minutes
Psychological Testing	15 minutes
Therapeutic Rehabilitation	15 minutes
Medication Prescribing and Monitoring	15 minutes
Physical Examinations	15 minutes
Screening	15 minutes
Assessment	15 minutes
Crisis Intervention	15 minutes

Service Planning	15 minutes
Screening, Brief Intervention, and Referral to Treatment	15 minutes
Mobile Crisis Services	1 hour
Assertive Community Treatment	Per Diem
Intensive Outpatient Program Services	Per Diem
Residential Crisis Stabilization Services	Per Diem
Residential Services for Substance Use Disorders	Per Diem
Partial Hospitalization	Per Diem
Day Treatment	1 hour
Comprehensive Community Support Services	15 minutes
Peer Support Services	15 minutes

(2) An initial unit of service which lasts less than:

(a) Fifteen (15) minutes for a service in which fifteen (15) minutes is the unit amount may be billed as one (1) unit; or

(b) The minimum amount for the service if the minimum amount is more than fifteen (15) minutes may be billed as one (1) unit.

(3) Except for an initial unit of a service, a service that is:

(a) Less than one-half (1/2) of one (1) unit shall be rounded down; or

(b) Equal to or greater than one-half (1/2) of one (1) unit shall be rounded up.

(4) An individual provider shall not exceed four (4) units of service in one (1) hour.

(5) An overpayment discovered as a result of an audit shall be settled through re-coupment or withholding.

[~~(6) A community mental health center shall maintain an acceptable accounting system to account for the:~~

~~(a) Cost of total services provided;~~

~~(b) Charges for total services rendered; and~~

~~(c) Charges for covered services rendered eligible recipients.~~

~~(7) A community mental health center shall make available to the department all recipient records and fiscal records:~~

~~(a) At the end of each fiscal reporting period;~~

~~(b) Upon request by the department; and~~

~~(c) Subject to reasonable prior notice by the department.~~

~~(8) Payments due a community mental health center shall be made at least once a month.~~

~~Section 4. Nonallowable Costs. The department shall not reimburse:~~

~~(1) Under the provisions of this administrative regulation for a service that is not covered by 907 KAR 1:044; or~~

~~(2) For a community mental health center's costs found unreasonable or nonallowable in accordance with the Community Mental Health Center Reimbursement Manual.~~]

Section 13.[~~5.~~] Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state community mental health center shall be the lesser of the:

(1) Charges for the service;

(2) Facility's rate as set by the state Medicaid Program in the other state; or

(3) Upper limit for that type of service in effect for Kentucky providers.

Section 14.[~~6.~~] Appeal Rights. A community mental health center may appeal a De-

partment for Medicaid Services decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 15.[~~7.~~] Not Applicable to Managed Care Organization. A managed care organization shall not be required to reimburse for community mental health center services in accordance with this administrative regulation.

Section 16.[~~8.~~] Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

(Recodified from 904 KAR 1:045, 5-2-1986; Am. 13 Ky.R. 387; eff. 9-4-1986; 14 Ky.R. 312; eff. 9-10-1987; 15 Ky.R. 1980; eff. 3-15-1989; 16 Ky.R. 9-20-1989; 17 Ky.R. 574; eff. 10-14-1990; 18 Ky.R. 916; eff. 10-16-1991; 19 Ky.R. 323; eff. 8-28-1992; 20 Ky.R. 664; eff. 10-21-1993; Am 1364; eff. 2-16-2004; 31 Ky.R. 461; 717; eff. 11-5-2004; 32 Ky.R. 405; 685; eff. 10-14-2005; TAm 7-16-2013; 40 Ky.R. 1959; 2492; 2721; eff. 7-7-2014.)

907 KAR 1:045

REVIEWED:

12/8/14
Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

12/18/14
Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 1:045

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 23, 2015 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing February 16, 2015, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business March 2, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:045
Contact person: Stuart Owen (502) 564-4321, extension 2015

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the Department for Medicaid Services' (DMS's) reimbursement provisions and requirements regarding community mental health center services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements regarding community mental health center services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing DMS's reimbursement provisions and requirements regarding community mental health center services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assist in the effective administration of the authorizing statutes by establishing DMS's reimbursement provisions and requirements regarding community mental health center services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment introduces a new cost-based reimbursement methodology and establishes reimbursement for primary care services (in concert with a companion administrative regulation – 907 KAR 1:046, Coverage provisions and requirements regarding community mental health center primary care service services.) Via the cost-based model, the Department for Medicaid Services (DMS) will ultimately reimburse for all services (behavioral health as well as primary care services) rendered during a given year based on Medicaid allowable costs after a thorough review of cost data reported by each CMHC to determine such costs for each CMHC. As a given CMHC's costs for a year is reported after the year concludes and DMS must review the cost data before determining the CMHC's total Medicaid allowable costs for the year, DMS reimburses each CMHC on an interim basis during the course of the year. After completing the review and determination of a CMHC's Medicaid allowable costs for a year, DMS will compare its interim reimbursement paid to the CMHC during the course of the year to the CMHC's actual Medicaid allowable costs for the year. If DMS's interim reimbursement to the CMHC exceeded the CMHC's Medicaid allowable costs, the CMHC will send the overpayment amount to DMS. If DMS's interim reimbursement was less than the CMHC's Medicaid allowable costs for the year, DMS will issue a lump sum payment to the CMHC equaling the amount owed. DMS's interim reimbursement for behavioral health services will be based on prior costs while its interim reimbursement for primary care services – new services covered in the scope of CMHC services – will be the reimbursement stated on the Kentucky-specific Medicare Physician Fee Schedule for the given service. If no reimbursement exists on the fee schedule for a given service, DMS will reimburse (again,

on an interim basis) for the service in the manner that it reimburses for physician's services pursuant to 907 KAR 3:010, Reimbursement for physician's services. The reimbursement established in this administrative regulation only applies to services rendered to Medicaid "fee-for-service" recipients. These are Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for CMHC services in accordance with this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment establishing a new cost-based reimbursement methodology is necessary as the Centers for Medicare and Medicaid Services (CMS) mandated that the Department for Medicaid Services (DMS) terminate its current CMHC services' reimbursement (effective January 1, 2015) and replace it with either a cost-based model or reimburse as Medicare does for the services. The mandate results in part from an audit of a CMHC by the Kentucky Auditor of Public Accounts. DMS shared the two (2) options with the chief executive officers (CEOs) of the CMHCs and the CEOs elected the cost-based reimbursement model. DMS's reimbursement of primary care services is necessary to comply with legislation (HB 527) enacted during the 2014 Regular Session of the General Assembly which was codified into KRS 205.6313.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments conform to the content of the authorizing statutes by revising Medicaid reimbursement for community mental health centers in a manner that complies with a federal mandate and with a state mandate.

(d) How the amendment will assist in the effective administration of the statutes: The amendments will assist in the effective administration of the authorizing statutes by revising Medicaid reimbursement for community mental health centers in a manner that complies with a federal mandate and with a state mandate.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers - there are fourteen (14) – will be affected by the amendment as will physicians, physician assistants, and advanced practice registered nurses who wish to provide primary care services in a CMHC.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. In order to be reimbursed by the Department for Medicaid Services CMHCs will have to annually submit cost report information to DMS stating all of the CMHCs Medicaid allowable costs, costs associated with care provided to recipients who are enrolled with a managed care organization, costs experienced by the Community Board for Mental Health or Individuals with an Intellectual Disability which oversees the CMHC; and costs associated with services covered by another payor/party. As mandated by the Centers for Medicare and Medicaid Services (CMS) the Medicaid "fee-for-service" costs of the CMHC must be clearly demarcated from the board's costs as well as the costs associ-

ated with care to recipients enrolled in an MCO. CMHCs that wish to be reimbursed for primary care services will need to employ (consistent with KRS 205.6313) physicians, physician assistants, or advanced practice registered nurses to provide primary care services.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). CMHCs will experience administrative costs associated with tracking and reporting costs data (including employing or contracting with personnel capable of accurately tracking and reporting the data). CMHCs that wish to provide primary care services will experience administrative costs in hiring the requisite personnel and purchasing or leasing associated equipment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs will benefit by receiving reimbursement from DMS for services to Medicaid recipient who are not enrolled with a managed care organization.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: Due to the uncertainty of how many CMHCs will elect to expand their scope of services to include primary care services and to the uncertainty of when such CMHCs will meet the associated licensure requirements established by the Office of Inspector General, DMS is unable to project a cost associated with this action. DMS does not anticipate a substantial change in costs associated with implementing the new cost-based reimbursement methodology mandated by CMS, but won't know the full impact until after receiving cost reports from CMHCs in the future.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation #: 907 KAR 1:045
Contact person: Stuart Owen (502) 564-4321, extension 2015

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(B).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect." KRS 205.6313 mandates that the Medicaid Program pay community mental health centers for primary service services at the same rates it pays primary care providers for such services

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the primary care provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation #: 907 KAR 1:045
Contact person: Stuart Owen (502) 564-4321, extension 2015

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6313.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? Due to the uncertainty of how many CMHCs will elect to expand their scope of services to include primary care services and to the uncertainty of when such CMHCs will meet the associated licensure requirements established by the Office of Inspector General, DMS is unable to project a cost associated with this action. DMS does not anticipate a substantial change in costs associated with implementing the new cost-based reimbursement methodology mandated by CMS, but won't know the full impact until after receiving cost reports from CMHCs in the future.

(d) How much will it cost to administer this program for subsequent years? The response in (c) above also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: